Supreme Court, U.S.
FILED
SEP 25 1995
CLERK

No. 95-98

In the Supreme Court of the United States

OCTOBER TERM, 1995

HILLSBOROUGH COUNTY HOSPITAL AUTHORITY, ET AL.,
PETITIONERS

v.

DONNA E. SHALALA,
SECRETARY OF HEALTH AND HUMAN SERVICES

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

BRIEF FOR THE RESPONDENT IN OPPOSITION

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QUESTION PRESENTED

Whether a now-superseded Medicare reimbursement provision, 42 U.S.C. 1395ww(b)(4)(A) (1982), was implicitly incorporated into another now-superseded reimbursement provision, 42 U.S.C. 1395ww(d)(1)(A)(i)-(ii) (Supp. V 1987), from 1983 to 1987.

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OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-4a) is reported at 49 F.3d 1416. The order of the district court (Pet. App. 7a-8a) and the report and recommendation of the magistrate judge (Pet. App. 11a-17a) are unreported.

JURISDICTION

The judgment of the court of appeals was entered on April 19, 1995. The petition for a writ of certiorari was filed on July 18, 1995. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

The issue in this case is whether 42 U.S.C. 1395ww(b)(4)(A) (1982), a now-superseded Medicare reimbursement provision, was incorporated into 42 U.S.C. 1395ww(d)(1)(A)(i)-(ii) (Supp. V 1987), another now-superseded reimbursement provision, from 1983 to 1987. This Court has recently denied certiorari in two other cases presenting the same issue, *Episcopal Hospital* v. *Shalala*, 114 S. Ct. 876 (1994), and *Methodist Hospital* v. *Shalala*, 114 S. Ct. 2162 (1994).

1. Petitioners are hospitals that are seeking retroactive increases in Medicare reimbursements for certain inpatient hospital care provided during the mid-1980s. Part A of the Medicare program provides elderly and disabled persons with "basic protection against the costs of hospital, related post-hospital, home health services, and hospice care." 42 U.S.C. 1395c (Supp. V 1993). Prior to 1983, hospital reimbursement under Part A was based primarily on the "reasonable cost" of covered services. 42 U.S.C. 1395f(b). The Medicare program defines "reasonable cost" to mean "the cost actually incurred," exclusive of costs "found to be unnecessary in the efficient delivery of needed health services." 42 U.S.C. 1395x (v)(1)(A). When a hospital's costs of providing covered services increased, so did its Part A reimbursement.

In 1982, in an effort to curb cost increases and encourage greater efficiency, Congress imposed greater limits on Part A reimbursement as part of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), Pub. L. No. 97-248, 96 Stat. 324. TEFRA left the basic retrospective, cost-based methodology of Part A reimbursement undisturbed, but added financial incentives and penalties to slow the rate of

increase in reimbursements for inpatient hospital services. See TEFRA § 101(a)(1), 96 Stat. 332-334.

TEFRA's rate-of-increase scheme was tied to a "target amount" for each hospital, which was defined in 42 U.S.C. 1395ww(b)(3)(A) (1982). For the hospital's initial cost reporting period, Subsection (b)(3)(A) defined "target amount" as "the allowable operating costs of inpatient hospital services * * * recognized * * * for such hospital for the preceding 12-month cost reporting period." 42 U.S.C. 1395ww(b)(3)(A)(i) (1982). For each subsequent reporting period, the target amount was increased annually by a specified percentage. 42 U.S.C. 1395ww(b)(3)(A)(ii) (1982). If a hospital's operating costs were less than the applicable target amount during a reporting period, the hospital received a bonus. 42 U.S.C. 1395ww(b)(1)(A) (1982). Conversely, if the hospital's operating costs exceeded the target amount, its reimbursement was reduced. 42 U.S.C. 1395ww(b)(1)(B) (1982); see generally 42 C.F.R. 413.40.

At the same time that TEFRA created a rate-of-increase limit on Part A reimbursements, it also provided for exceptions and adjustments under 42 U.S.C. 1395ww(b)(4)(A) (1982). Subsection (b)(4)(A) generally authorized the Secretary of Health and Human Services to "provide for such * * * exemptions from, and exceptions and adjustments to, [the rate-of-increase reimbursement] method as the Secretary deems appropriate." 42 U.S.C. 1395ww(b)(4)(A) (1982); see generally 42 C.F.R. 413.40(e)-(i). Subsection (b)(4)(A) also specifically directed the Secretary to "provide for an exemption from, or an exception and adjustment to, the [rate-of-increase] method * * * where events beyond the hospital's control or extraordinary circumstances * * * create a

distortion in the increase in costs for a cost reporting period." 42 U.S.C. 1395ww(b)(4)(A) (1982); see 42 C.F.R. 413.40(g)(2).

2. In 1983, Congress replaced TEFRA's rate-of-increase limits with a more ambitious and far-reaching reform of Part A reimbursement, the Prospective Payment System (PPS).[1] See 42 U.S.C. 1395ww(d) (1988 & Supp. V 1993). Under the PPS, hospitals are reimbursed for inpatient costs on the basis of prospectively determined federal rates, rather than actual operating costs. 42 U.S.C. 1395ww(d)(1) and (4) (1988 & Supp. V 1993); see 42 C.F.R. 412.60.[2] The PPS provides for largely uniform payment rates calculated on the basis of national and regional reimbursement rates for each patient discharge category, known as a diagnosis-related group. 42 U.S.C. 1395ww(d)(2)-(3) (1988 & Supp. V 1993); see 42 C.F.R. 412.62, 412.63.

Because PPS reimbursement does not depend on an individual hospital's actual costs, reimbursement rates can be determined prospectively. If an individual hospital's costs exceed the prospective federal rates, the PPS requires the hospital to absorb the difference as an operating loss. Conversely, if the hospital's costs are lower than the prospective federal rates, the hospital retains the difference. This

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[1] Several categories of hospitals have been exempted from the PPS and are still reimbursed under the prior TEFRA provisions. See 42 U.S.C. 1395ww(d)(1)(B) (1988 & Supp. V 1993).

[2] In October, 1991, a separate prospective payment system was established for capital costs. See generally 42 U.S.C. 1395ww(g) (1988 & Supp. V 1993); 42 C.F.R. 412.300 *et seq.* This case concerns pre-1991 cost reporting periods and does not involve any dispute over capital costs.

reimbursement scheme was "intended to reform the financial incentives hospitals face, promoting efficiency * * * by rewarding cost[-]effective hospital practices." H.R. Rep. No. 25, 98th Cong., 1st Sess. Pt. 1, at 132 (1983).

In order "to minimize disruptions that might otherwise occur because of a sudden change in reimbursement policy," Congress phased in the PPS by creating a transition period from 1983 to 1987. H.R. Rep. No. 25, *supra*, at 136. The reimbursement controversy in this case concerns that now-expired PPS transition period. During the transition period, inpatient hospital services were reimbursed on the basis of blended rates, which consisted of two components. The first component was a percentage of the prospective federal rate under the PPS. 42 U.S.C. 1395ww(d)(1)(A)(i)(II) and (ii)(II) (Supp. V 1987). The second component, known as the hospital-specific portion (HSP), was a specified percentage of the hospital's "target amount" for the cost reporting period. 42 U.S.C. 1395ww(d)(1)(A)(i)(I) and (ii)(I) (Supp. V 1987). Over the course of the four-year transition period, the portion of the reimbursement amount tied to the prospective rate became progressively larger and the portion tied to the HSP became progressively smaller. The HSP was eventually phased out altogether, and the prospective rate thereafter formed the exclusive basis for PPS reimbursement. 42 U.S.C. 1395ww(d)(1)(C) (Supp. V 1987).

The present case involves the calculation of the HSP's "target amount." To define the "target amount" used during the PPS transition period, Congress borrowed the definition it had used earlier in TEFRA: Congress directed the Secretary to use "the hospital's target amount for the cost reporting

period (as defined in subsection (b)(3)(A) of this section * * *)." 42 U.S.C. 1395ww(d)(1)(A)(i)(I) and (ii)(I) (Supp. V 1987). Thus, to calculate a hospital's "target amount" during the PPS transition period, the Secretary was required to determine the allowable costs during the 12-month reporting period preceding the first TEFRA year, known as the base year, then increase that figure by the specified percentages for subsequent periods. See 42 U.S.C. 1395ww(b)(3)(A) (1982); see page 3, *supra*.

When Congress created the PPS, it provided in 42 U.S.C. 1395ww(d)(5) (1988 & Supp. V 1993) for various exceptions and adjustments, just as it had done earlier when it enacted TEFRA. Congress gave the Secretary similar general authority under the PPS to establish "such * * * exceptions and adjustments to * * * payment amounts under this subsection as the Secretary deems appropriate." 42 U.S.C. 1395ww(d)(5)(I) (Supp. V 1993). That subsection also directs the Secretary to implement a number of specific exceptions and adjustments. 42 U.S.C. 1395ww(d)(5)(A)-(H) (1988 & Supp. V 1993). In contrast to TEFRA's analogous provision, however, Subsection (d)(5) does not direct the Secretary to adjust reimbursement amounts where "extraordinary circumstances" distort the increase in costs for a particular cost reporting period.

The PPS's transition-period reimbursement provisions are implemented in regulations found at 42 C.F.R. 412.70-412.76. Among other things, the regulations specify a limited number of situations in which the "target amount" used to calculate the HSP may be modified to reflect costs other than allowable base-year costs. See 42 C.F.R. 412.71(b)-(c), 412.72(a). Notably, however, the regulations do not authorize

modification of the target amount to take into account cost increases occurring after the base year.

3. Petitioners are 114 Florida hospitals that are seeking increased Medicare reimbursement for the now-concluded PPS transition period. Petitioners claim to have experienced an increase in operating costs beginning in 1984, after the end of the base year used to determine the "target amount" under Subsection (b)(3)(A), due to Florida's imposition of a recurring "Indigent Health Care Program" assessment (Pet. App. 13a-14a). Petitioners sought increased reimbursements on the basis of Subsection (b)(4)(A). The Secretary denied the adjustment requests on the ground that Subsection (b)(4)(A) did not apply to the PPS transition period and that post-base-year cost increases did not qualify for adjustment under the PPS transition-period reimbursement rules.

Petitioners brought suit against the Secretary in the District Court for the Middle District of Florida. The district court referred the case to a magistrate judge, who recommended that the court grant summary judgment in favor of the Secretary. Pet. App. 11a-17a. The district court adopted the magistrate judge's recommendation, *id.* at 7a-8a, and petitioners appealed. The court of appeals affirmed the district court in a *per curiam* opinion, agreeing with the reasoning of the District of Columbia Circuit in *Episcopal Hospital* v. *Shalala*, 994 F.2d 879 (1993), cert. denied, 114 S. Ct. 876 (1994), and the Third Circuit in *Sacred Heart Medical Center* v. *Sullivan*, 958 F.2d 537 (1992). See Pet. App. 3a-4a.

ARGUMENT

The question presented by petitioners in this case is whether 42 U.S.C. 1395ww(b)(4)(A) (1982) was implicitly incorporated into the now-superseded provisions that governed Medicare reimbursement during the PPS transition period from 1983 to 1987. As petitioners concede (Pet. 9), the identical issue was presented two Terms ago in *Episcopal Hospital* v. *Shalala*, 114 S. Ct. 876 (1994), and *Methodist Hospital* v. *Shalala*, 114 S. Ct. 2162 (1994), and this Court denied certiorari on both occasions. The Court should deny certiorari in this case for the same reasons.

1. Our brief in opposition in *Episcopal Hospital* set forth the considerations that militate against review of the issue by this Court.[3] As we explained there in detail, the statute's language, structure, and purpose indicate that the PPS transition-period provisions did not incorporate Subsection (b)(4)(A). Equally important, the legal dispute resolved by the court of appeals concerns the relationship between two now-superseded reimbursement provisions, neither of which applies to cost reporting periods after 1987. The issue that petitioners raise therefore continues to lack the sort of ongoing significance that would warrant review by this Court.[4]

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[3] We have furnished counsel for petitioners with copies of our briefs in opposition in *Episcopal Hospital* and *Methodist Hospital*.

[4] Petitioners point out (Pet. 9, 12) that the Ninth Circuit reached a contrary result in *Community Hospital of Chandler* v. *Sullivan*, 963 F.2d 1206, 1213-1214 (1992). As we explained in our brief in opposition (at 14-15 & n.8) in *Episcopal Hospital* (No. 93-429), however, the Ninth Circuit ruled on the issues

2. Petitioners suggest that the denial of certiorari in *Episcopal Hospital* should not foreclose further review in this case because the Subsection (b)(4)(A) issue was not cleanly presented in that case. Petitioners assert (Pet. 9) that the decision of the court of appeals in *Episcopal Hospital* rested on an independent ground that was not challenged in the certiorari petition—namely, a determination by the court of appeals that the hospitals in *Episcopal Hospital* did not meet the criteria for relief under Subsection (b)(4)(A). The petitioners in *Methodist Hospital* unsuccessfully sought to distinguish *Episcopal Hospital* on the same theory. See Pet. at 3, *Methodist Hospital* v. *Shalala*, 114 S. Ct. 2162 (1994) (No. 93-1449).

Contrary to petitioners' assertion, the court of appeals in *Episcopal Hospital* never determined that the hospitals failed to meet the criteria for relief under Subsection (b)(4)(A). Although the district court in *Episcopal Hospital* had made such a determination, the court of appeals did not reach that issue. Instead, the court of appeals terminated its analysis with the conclusion that Subsection (b)(4)(A) did not apply to the PPS transition period. That conclusion rendered irrelevant the further issue whether the

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without benefit of briefing by the Secretary (since the issues had not been raised and therefore appeared to have been waived), and the government chose not to seek certiorari in that case because of the limited significance of the issue. Moreover, as the magistrate judge in this case observed (Pet. App. 16a-17a), the Ninth Circuit in *Community Hospital of Chandler* failed to address certain critical points, including the principle of deference to the Secretary's interpretation and the significance of the separate exemption and adjustment provisions under the PPS system.

hospitals met Subsection (b)(4)(A)'s requirements. See 994 F.2d at 883-884.[5] As a result, the petition in *Episcopal Hospital*, as well as the subsequent petition in *Methodist Hospital*, squarely presented the same Subsection (b)(4)(A) issue that is being advanced in the current petition.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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SEPTEMBER 1995

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[5] The court of appeals also addressed the issue whether the Secretary was otherwise obligated, apart from Subsection (b)(4)(A), to grant the hospitals the adjustments they sought. See 994 F.2d at 884. It concluded that she was not. *Ibid.*